

Dutt and Stead from the United States recommend a regimen consisting of rifampin (600 mg) and isoniazid (300 mg) given daily for about two months, followed by rifampin (600 mg) and isoniazid 15 mg per kg of body weight) daily or twice a week (depending on patient reliability) for another seven months. They add ethambutol hydrochloride (15 mg per kg) during the first two months if a patient has shown high initial drug resistance.

Many centers now recommend without reservation short-course chemotherapy for the initial treatment of genitourinary tuberculosis. The results may be even better than in pulmonary tuberculosis because fewer bacilli are usually found in renal lesions and rifampin is highly concentrated in the urine.

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### Single-Dose Therapy for Lower Urinary Tract Infection

ACUTE CYSTITIS is one of the two most frequent indications for administering antimicrobial therapy in adult women. Recent studies have shown that in non-pregnant adult women single-dose antimicrobial therapy may be as effective as conventional 7- to 14-day regimens.

Controlled trials have shown that amoxicillin trihydrate, sulfisoxazole and trimethoprim-sulfamethoxazole are effective when given in single-dose regimens in this population. In contrast, cephaloridine, cefaclor and cephalexin monohydrate have been shown to be poor choices. Caution should be exercised in extrapolating data to other agents without appropriate clinical evaluation. Likewise, single-dose regimens have been less effective than conventional treatment in pregnant women and children and should not be used in these patients.

Potential benefits of single-dose therapy include reduced medication costs, improved patient compliance with drug regimens, fewer side effects and a reduction in the rate of emergence of resistant bacteria. Additionally, the failure of a single-dose regimen to eradicate bacteriuria (when the organism is sensitive) may indicate more invasive infections and, some suggest, a need for closer follow-up and more extensive investigation to identify structural or functional abnormalities of the urinary tract. Careful bacteriologic follow-up evaluation should be done irrespective of the duration of therapy.

Although information regarding optimal choice and dose of an antimicrobial agent for single-dose treatment remains to be refined, oral amoxicillin (2.0 grams), sulfisoxazole (1.0 grams) or trimethoprim-sulfamethoxazole (160 and 800 mg, respectively) appear to be rational choices.

Administration of single-dose antibiotic drugs for lower urinary tract infection is safe and effective therapy for nonpregnant adult women.

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### Hospital Admission Rates in Men Who Have Had Vasectomies

FEARS based on findings from studies in animals about the long-term health of men who have had vasectomies have not been borne out in a large follow-up study. Using the records of a large health maintenance organization, the incidence of first hospital admission after vasectomy in 6,092 men (20,491 man-years of follow-up) was evaluated. Hospital admissions for various classes of disease and for a variety of specific illnesses were compared with the rates in members of the same health maintenance organization who had not had vasectomies. There was no evidence of an increased prevalence of arteriosclerotic disease in the men who had had vasectomies, the principal concern raised by the experiments in animals. The highest standardized rate ratio (vasectomized to nonvasectomized) for first hospital admissions was for diseases of the genitourinary system, whose diagnosis may have been prompted by the vasectomy.

These findings were further evaluated according to time since the vasectomy because it was assumed that hospital admittance causally associated with vasectomy would either increase or decrease in frequency in some regular fashion with time. No specific disease entity followed this pattern, with the exception of hospital admissions for mental disorders, which were less frequent in men who had had vasectomies than in men who had not and continued to decline with time after the vasectomy procedure.

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### Computerized Tomography, Lymphangiography and Gleason Scores for Staging Prostatic Adenocarcinoma

IT HAS BEEN well documented that the prognosis and metastatic progression of disease in patients who have adenocarcinoma of the prostate is determined by the presence or absence of pelvic lymph node metastasis. There is no information that supports an increased survival with either pelvic lymph node dissection or pelvic lymph node irradiation. The accurate preopera-

tive classification of patients who have or do not have positive lymph node involvement is therefore indicated to determine the aggressiveness of therapy and avoid unnecessary surgical procedures and irradiation.

The usefulness and accuracy of computerized tomography, lymphangiography and Gleason categories were evaluated in 53 patients who had clinical stage A, B or small C lesions. All 53 patients were candidates for interstitial irradiation and had had staging lymphadenectomy. Of the total of 53 patients, 50 had lymphangiography, 23 computerized tomographic scanning and 48 had Gleason scores assigned. The accuracy of lymphangiography was 58 percent, with a 12 percent false-positive and a 30 percent false-negative rate. The accuracy of computerized tomography in this series is 50 percent, with a false-positive rate of 14 percent and a false-negative rate of 36 percent. Correlation of Gleason scores shows no lymph node metastasis with Gleason scores of 5 and 6, 37.5 percent with scores of 7, 36 percent with scores of 8, 63.7 percent with scores of 9 and 100 percent with scores of 10. Combining computerized tomography and lymphangiography or lymphangiography and Gleason scores did not significantly increase the staging accuracy.

These findings confirm those of Benson and co-workers and Kramer and associates that show the

inaccuracy of lymphangiography and computerized tomographic scanning and support the reliability of Gleason scores for preoperative staging.

In conclusion, lymphangiography and computerized tomographic scanning are not consistently accurate in preoperative staging and should not be routinely used. Gleason categorization is more accurate and reliable than lymphangiography or computerized tomographic scanning alone or in combination. Routine staging lymphadenectomy can be avoided in patients who have Gleason scores below 5 and in patients above 9. Intermediate groups with scores of 7 and 8 need lymphadenectomy to document pelvic node disease. Aggressive therapy should be considered in patients who have Gleason scores 2 through 8.

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